Transparency in Coverage Rules for Group Health Plans

In 2020, the Department of Labor, Department of Treasury, and the Department of Health and Human Services released the final rules on the Transparency in Coverage requirements. The goal behind the release of these new Transparency Rules is to "put health care price information in the hands of consumers… to empower them to make informed healthcare decisions." There is also the hope that through the release of pricing information there will be greater competition which will hopefully bring pricing down.

One of the upcoming implementation dates applicable to group health plans begins January 1, 2022. As per the new Transparency Rules, plan years that begin on or after January 1, 2022 must post pricing information on the plan's or insurer's website. This information must be publicly accessible, free of charge to those accessing it, and it must be updated monthly. Disclosures must contain specific content and must be provided on *three (3) machine readable files* that must include:

1. Negotiated rates for all items and services with in-network providers (except prescription drugs),
2. Payments to, and billed charges from, out-of-network providers during a specified period, and
3. Negotiated rates for prescription drugs furnished by in-network providers during a specified period.

The above requirement only applies to non-grandfathered health plans and insurers. These Transparency requirements do not apply to grandfathered group health plans, excepted benefits (e.g., stand-alone dental and vision), Health Reimbursement Arrangements (HRAs) or other account-based plans.

For fully insured plans, the insurer for the plan will make the transparency information available on behalf of an insured plan if required by a written agreement. In that case, the insurer and not the plan sponsor would be responsible for compliance with the transparency disclosures.

For self-funded plans, the plan will likely want to contract with its third-party administrator ("TPA") or pharmacy benefit manager ("PBM") for them to make the transparency disclosures. Self-funded plans should keep in mind though that if the TPA fails to comply with the disclosure rules, the plan sponsor will remain responsible. If either the plan or its TPA fail to comply with the disclosure rules, the plan could be subject to a $100 per day excise tax penalty. The Transparency Rules do contain a "good faith" safe harbor whereby if a plan or insurer acts in good faith but makes an error, they can avoid penalties by making a correction as soon as possible.

Many carriers/TPAs/PBMs are just now starting to reach out to clients to discuss their approach to compliance with these Transparency Rule requirements. We anticipate carriers/TPAs/PBMs will be reaching out to clients in the near future.

McGohan Brabender has been in touch with several TPAs and PBMs who have said that they are aware of the Transparency Rule requirements and are working on this. Additional guidance will be provided by the Departments in the near future regarding the Transparency Rule requirements and how to comply. McGohan Brabender will keep you updated as additional guidance is released.